

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-037658

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 36

FILED NOV 7 1962

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Centralia</u>		c. CITY OR TOWN <u>Centralia</u>	
Length of stay in 1b <u>1 month</u>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Way Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>326 North Allen</u>	
Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mayme</u> Middle <u>Sander</u> Last <u>Sander</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/1878</u>
9. AGE (last birthday) <u>84</u>	10. CAUSE OF DEATH (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>August Sander</u>	
13b. MOTHER'S MAIDEN NAME <u>Marie Wetteroth</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>August Sander, Centralia, Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia bilateral</u> DUE TO (b) <u>Senile debility</u> DUE TO (c) <u>Arteriosclerosis generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 month</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension arterial duration unknown</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>6:25</u> a.m. <u>p.m.</u> Month, Day, Year <u>June, 1954</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Centralia</u>	
20g. COUNTY <u>Boone</u>		20h. STATE <u>Mo</u>	
21. I attended the deceased from <u>June, 1954</u> to <u>October, 1962</u> and last saw her alive on <u>October 25, 1962</u> Death occurred at <u>6:25 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>L. LaChance, M.D.</u>	
22b. ADDRESS <u>110 W. Sneed, Centralia, Missouri</u>		22c. DATE SIGNED <u>10/30/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 30, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Centralia</u>	23d. LOCATION (City, town, or county) (State) <u>Centralia, Missouri</u>
24. EMBELMER'S STATEMENT (Address) <u>Bill J. Meador, Centralia, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 30 - 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Maud M. Bride</u>			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

DATE AMENDED

1 0101

2 01012

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9 444X

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11

12 86-0

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(Licensed Embelmer's Statement on Reverse Side)

NOV 7 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

P. J. Mado

Licensed Embalmer No. 4876

P. O. Address Centuria, Miami

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Permit issued Oct 30, 1962. 7948.